STATE OF NEVADA

KENNY C. GUINN
Governor

MICHAEL J. WILLDEN
Director

ALEX HAARTZ, MPH
Administrator

BRADFORD LEE, M.D.
State Health Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH DIVISION
BUREAU OF FAMILY HEALTH SERVICES
3427 Goni Road, Suite 108
Carson City, NV 89706
(775) 684-4285 - Fax (775) 684-4245

Date:_____

Dear Applicant:

Enclosed is the application you have requested from the Bureau of Family Health Services, CSHCN Program. Starting at the client name, please answer all questions except for the shaded areas.

The attached instruction sheet outlines the documentation we require. If you have any questions, please call (775) 684-4285, or our toll free number at (866) 254-3964.

Please be sure to sign and date where indicated, and return to the above address within 15 days.

If the family's income is low, you **MUST APPLY** for the Nevada State Medicaid Program at (775) 684-7200 for Northern Nevada, or (702) 486-1646 for Southern Nevada.

If the client is under 18 years of age, and has been denied Medicaid due to excess income, you **MUST APPLY** for the Nevada Check Up Program at (800) 360-6044.

Sincerely,

Children's Special Health Care Needs Program
Bureau of Family Health Services

Enclosures

FAMILY HEALTH SERVICES APPLICATION

RETURN APPLICATION BY: _____ PHONE: (775) 684-4285

Attached is an Application, a Parent's Rights and Responsibilities form, a Medical Release Form, and an Insurance Verification Form. Please PRINT and give COMPLETE INFORMATION. Failure to give complete information could result in a delay in the application process, or in being denied program coverage. If you cannot return these forms within the 15 working days – please call for an extension. If the completed application is not returned on time – we can not cover the child from the initial date of contact. Late returns will commence coverage on the date the application is received in our office. Incomplete applications will be returned, which will cause a delay in processing and eligibility.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION
DO NOT WRITE IN THE SHADED AREAS.

DIVORCED/SEPARATED FAMILIES – read information on page 3 before completing the application.
GUARDIAN/GRANDPARENT – read instructions on page 4 before completing the application.

BASIC INFORMATION

Client's name as it appears on the birth certificate (if married use married name)
Mark gender – male **M** □ female **F** □
Age
Date of Birth (ex. 01/02/2003)
Copy of Social Security card.
Physical address - where client actually lives.
Mailing address (if different than physical address.)
County – county in which the client lives.
Client lives with: Both Parents, Mother, Father, Foster Parent(s) Other (state relationship – friend, aunt, etc.)
Ethnic Background: check appropriate box.
Phone – home phone number. (Also, complete Father's and Mother's work phone numbers, message phone number).

MARITAL STATUS OF PARENTS

Mother/Father – (married, divorced, separated etc.)
CUSTODY STATUS: For divorced/separated parents:
Physical Custodian: person granted by legal court documents
Legal Custody: person(s) granted by legal court documents, i.e. mother, father, joint etc.

HEALTH INSURANCE

List all policies covering the CLIENT and the name of the policy holder (who is carrying the insurance: Father, Mother, Other – Step-Parent, Self, or Spouse.) List the Company's name, address, policy group ID no. and the effective date.

MEDICAL INFORMATION – VERY IMPORTANT – GIVE COMPLETE INFORMATION

DOCTOR/HOSPITAL INFORMATION

Family Physician. (or child's Pediatrician). Give Doctor's first & last name, complete address with zip code, phone number, and the date client last saw this physician. LEAVE RECORDS REQ. AREA BLANK.

Specialist. (Give the name(s), complete address with zip code, phone number and the date the child was seen or will be seen). LEAVE OTHER AREAS BLANK

If there are additional specialists being seen or who have been referred then list them on a separate sheet of paper.

Hospital – if more than one hospitalization recently – list additional information under the condition section or list on a separate sheet of paper– be sure to include the dates admitted.

CONDITION FOR WHICH REFERRAL IS MADE: Give the name of the diagnosed condition OR state the condition for which the doctor is testing. (Give a specific condition – if necessary contact your physician's office for the name of the condition.) Please attach a copy of the medical report, records or physician's referral for review.

INCOME: (PAGE 2 OF APPLICATION)

HOUSEHOLD COMPOSITION - **MEANS EVERYONE RESIDING IN THE HOME.** LIST ALL HOUSEHOLD MEMBER'S and their relationship to the client (i.e. father, mother, brother, sister, friend, aunt, etc.) Include full names, date of birth, Social Security number, and income for each individual.

List everyone who is employed in the household, their employer's name and address. Include job title and/occupation. State how often they receive paychecks (i.e. weekly, bi-weekly, 2 times/month, monthly).

OTHER INCOME RESOURCES: List any or all that may apply: TANF, child support, tips, social security, supplemental security income, retirement, veteran's benefits, EICON (worker's compensation), unemployment benefits, insurance payments, disability benefits, and proof of any other lump sum or periodic payments etc.

GROSS LIQUID ASSETS: Savings, stocks, bonds, trust funds, retirement plans, 401K, IRA's etc.

NUMBER DEPENDENT ON INCOME – list dependents.

SUPPORTING DOCUMENTATION

Attach copies of 3 pay stubs for each person employed –. INCLUDE THE DATE THE INDIVIDUAL STARTED WITH THAT COMPANY.

Self – employed – attach copies of income tax return for the last calendar year.

ABSENT PARENT'S NAME: Give the complete name and address. (Incomplete information will delay the application).

OTHER PERTINENT INFORMATION – List other programs for which you have applied and the date of application. (i.e. SSI, Medicaid, Nevada Check Up)

ADDITIONAL FORMS TO BE COMPLETED & SUBMITTED WITH APPLICATIONS

APPLICANT'S/CLIENT RESPONSIBILITY AGREEMENT

READ THIS CAREFULLY AND THOUROUGHLY – IT IS VERY IMPORTANT THAT YOU UNDERSTAND WHAT IS EXPECTED OF YOU IN ORDER FOR THE BUREAU OF FAMILY HEALTH SERVICES TO ASSIST WITH PAYMENT FOR SERVICES.

AUTHORIZATION FOR RELEASE OF INFORMATION

We have enclosed a release of information authorization form for you to sign. We will copy and send it to the providers you have listed on the application for medical records. We need this form to confirm a diagnosis and pay future bill. The original release will remain in our file in case there is a need for additional medical records.

INSURANCE VERIFICATION – your insurance is classified as a prior resource to any governmental programs. You will need to follow your insurance guidelines for services. You must verify that the provider of care works with both your insurance company and the Children with Special Health Care Needs Program. (We will send a form to your insurance company for completion.)

Fill out the following sections only:

On the left hand side – fill in the name and address of your insurance company.
On the right hand side – fill in the information requested.
DO NOT ANSWER QUESTIONS 1-6 – this is for your insurance carrier
At the bottom of the page – sign where indicated, give relationship to the insured and the date signed.
RETURN THIS FORM WITH YOUR APPLICATION.

DIVORCED/SEPARATED PARENTS' INFORMATION

Separated parents (undocumented) are counted as intact families – submit absent parent's address and income verification with the application. The absent parent is equally responsible for the child.

Legal separation – copy of the legal court document(s) is required. Submit the absent parent's address.

Divorced parents – The Bureau of Family Health Services abides by the court approved divorce decree and child custody documents. (We will need the absent parent's address, if that parent has joint custody or is equally responsible for a part of the medical bills.) The absent parent will receive an application to complete. He/She will be assigned 100% of their half of the medical bills for failure to return their portion of the application.

GUARDIAN/GRANDPARENT –The Bureau of Family Health Services (BFHS) accepts applications with legal court appointed guardianship documentation. Notarized statements are **NOT** accepted. The family will need to apply of the Nevada State Welfare – non needy caretaker program. A copy of the Welfare determination will be needed in order to continue the BFHS application process.

DOCUMENTATION REQUIRED WITH APPLICATIONS – YOU MUST INCLUDE COPIES OF THIS DOCUMENATION WITH THE APPLICATION. DO NOT SEND ORIGINAL DOCUMENTS.

Copy of Birth Certificate
Copies of immigration or citizenship papers/alien registration cards.
Copy of Social Security card for the client.
Copies of 3 wage stubs or wage statements from present employer for each employed person in the household.
State how paid: i.e. weekly, bi-weekly, twice monthly, monthly etc.
Copies of W-2 forms.
Self-Employed – Copies of Income Tax Return for the previous year.
Copies of Award letter(s) or copy of check(s) for all other income listed.
Copies of the latest stock, bond, savings, trust funds, 401K, IRA'S information.

Information regarding any litigation/damage related to injuries of the client being enrolled in this program.
Copies of all divorce, separation documents and court orders for any child support.
Copies of documentation showing paternity of the person for whom you are applying.
Copy of insurance card. (front and back)
Copies of documentation for completed adoptions.
Copy of benefit determination (I.e. insurance denial, Medicaid denial etc.)
Insurance Verification form.
Signed authorization for release of information.

RETURN ALL FORMS TO:

NEVADA STATE HEALTH DIVISION
Bureau of Family Health Services – CSHCN
3427 Goni Road – Suite 108
Carson City, NV 89706-4245

Phone: (775) 684-4285 **FAX: (775) 684-5840**
Toll free: (866) 254-3964

APLICACIÓN DE SERVICIOS DE SALUD PARA LA FAMILIA

REGRESE LA APLICACIÓN ANTES DE:_____NUMERO DE TELEFONO: (775) 684-4285

Adjuntas está una Aplicación, Derechos de Los Padres y Responsabilidades, Formulario Medico para Liberar Expedientes Medicales, y un Formulario de Verificación de Seguro Medico. Favor de ESCRIBIR Y DAR INFORMACIÓN COMPLETA. El no dar la información completa, puede resultar en retraso del proceso de la aplicación o ser negado cobertura del programa. Si usted no puede regresar estos formularios dentro de 15 días laborales, favor de llamar par recibir una extensión. Si la aplicación no es regresada a tiempo nosotros no podemos cubrir a su niño (a) en la fecha inicial, la fecha efectiva será la fecha en que la aplicación sea recibida actualmente. Aplicaciones incompletas serán devolvidas y causaran retraso en el proceso.

INSTRUCIONES PARA COMPLETAR ESTA APLICACIÓN- NO ESCRIBA EN LAS AREAS QUE ESTAN EN GRIS.

FAMILIAS DIVORCIADAS/SEPARADAS - Lea la información en la página 3 antes de completar la aplicación
GUARDIÁN/ABUELOS - Lea la información en la página 4 antes de completar la aplicación.

INFORMACIÓN BASICA
Nombre del cliente como aparece en su acta de nacimiento (Si esta casado(a) use su nombre de casado(a)).
Marque el género del cliente masculino- **M** □ o femenino- **F** □
Edad
Fecha de Nacimiento: (ejemplo 01/02/2003)
Numero de Seguro Social
Dirección física donde vive el cliente actualmente
Dirección de correo si es diferente a la dirección física
Condado - es el condado donde vive el cliente
El cliente vive con: Ambos Padres □ Madre□ Padres Adoptivos □ Otro □ (Indique la relación: con un amigo, con el esposo(a), con una tía, etc.)
Origen étnico: señale la caja apropiada
Numero de Teléfono - es el numero de teléfono de su casa - Escriba el numero de trabajo del padre y la madre.
Numero telefónico donde se pueda dejar un mensaje.

ESTADO CIVIL DE LOS PADRES
Madre/Padre (casados, divorciados, o separados).
ESTADO DE CUSTODIA: Para los padres divorciados o separados:
Guardián Físico: Persona ala que la custodia fue concedida por documentos legales de la corte.
Custodia Legal: persona(s) al que le fue concedida la custodia por documentos legales por la corte, es decir madre, padre, o ambos, etc.

SEGURO MEDICO
Escriba todas las pólizas de seguro que cubren al CLIENTE y por parte de quien esta asegurado, (ya sea el padre, la madre, madrastra, padrastro, cónyuge, o el cliente mismo.) Escriba el nombre de la compañía del seguro, dirección, el número de identificación del grupo de su póliza, y la fecha efectiva.

INFORMACIÓN MÉDICA – MUY IMPORTANTE - QUE DE INFORMACIÓN COMPLETA

INFORMACIÓN DE DOCTOR/HOSPITAL

Medico Familiar (o pediatra del niño(a)) – Escriba el nombre y apellido del doctor, numero de teléfono, fecha en que el cliente visito al doctor, dirección y código postal – DEJE EL REQUERIDO EXPEDIENTES EN BLANCO.

Especialista - Escriba el nombre y apellido, número de teléfono, dirección, del especialista y la fecha en que visito o va hacer visto el cliente. DEJE LO DEMÁS EN BLANCO.

Escriba los nombres de otros especialistas o doctores, que el cliente a sido referido o a visitado en una hoja de papel adicional.

Hospital - (al que el cliente a sido admitido previamente por su condición) – si más de una hospitalización a ocurrido recientemente, escriba la información adicional en la sección de condiciones – asegurase de escribir las fechas en que a sido hospitalizado.

CONDICIÓN POR LA CUAL LA CONSULTA FUE HECHA: Escriba el nombre de la condición diagnosticada o escriba el nombre de la condición por la cual el doctor a examinado al cliente. Llame a la oficina del doctor para que le den el nombre de la condición especifica. Usted puede incluir una copia del informe, expediente o remisión del doctor.

INGRESOS: (PAGINA 2 DE LA APLICACIÓN)

COMPOSICIÓN FAMILIAR – MIEMBROS DE FAMILIA (Significa todo los que residen en el hogar.)
ESCRIBA LA RELACIÓN DE TODOS LOS MIEMBROS DEL HOGAR (ejemplo: padre, madre, hermano, hermana, amigo, tía, etc.), nombre completo, fecha de nacimiento y numero de seguro social.

Escriba todos los que trabajan en el hogar, el nombre de la compañía, dirección, ocupación y titulo de trabajo. Escriba que tan frecuente recibe cheques (ejemplo semanal, cada dos semanas o mensual).

OTROS RECURSOS DE INGRESO: Ayuda gubernamental, sostenimiento del niño(a), propinas, seguro social, seguridad de ingreso suplemental, ingresos de retiro, beneficios de: veteranos, desempleo, seguro medico, invalides, y pruebas de cualquier suma de ingresos recibidos.

BIENES LÍQUIDOS: Ahorros, acciones, bonos, fondos fiduciarios, planes de retiro, 401K, IRA's, etc.

NUMERO DE MIEMBROS QUE DEPENDEN DE LOS INGRESOS – Escriba todos sus dependientes.

DOCUMENTACIÓN DE INGRESOS

Adjunte 3 copias de talones de cheque por cada persona que trabaja – ESCRIBA LA FECHA CUANDO EMPEZÓ A TRABAJAR CON LA COMPAÑÍA.
Si tiene su propio negocio – adjunte copias de reembolso de impuestos del año anterior.

NOMBRE DE PADRE(S) AUSENTE(S): – Escriba el nombre completo y dirección. (Información incompleta retrasara la aplicación).

OTRA INFORMACIÓN PERTINENTE – Escriba si a aplicado para otros programas, por ejemplo, SSI/Medicaid, Katie Beckett, Nevada Check Up.

FORMAS ADICIONALES QUE DEBEN SER COMPLETADAS Y SOMETIDAS CON LA APLICACIÓN

ACUERDO DE RESPONABILIDAD DEL CLIENTE/CANDIDATO
LEA CUIDADOSAMENTE Y A FONDO – ES MUN IMPORTANTE QUE USTED ENTIENDA LO QUE SE ESPERA DE USTED EN ORDEN PARA QUE LOS SERVICIOS MEDICOS PARA LA FAMILIA ASISTAN EN PAGAR LOS SERVICIOS MÉDICOS.

AUTORIZACIÓN PARA LIBERAR INFORMACIÓN
Hemos incluido un formulario de autorización para liberar información para que usted la firme. Enviaremos copias de las forma a los proveedores medicos que usted a escribido en la aplicación para pedir los expedientes médicos. Necesitamos este formulario para confirmar el diagnostico para pagar futura cuentas. El formulario original permanecerá en nuestros archivos en caso de que necesitemos expedientes médicos adicionales.

VERIFICACIÓN DEL SEGURO MEDICO - Su seguro es clasificado como un recurso primario antes de cualquier programa gubernamental. Usted también necesitara seguir las reglas de los servicios de su seguro. Usted necesita verificar que el proveedor de servicios médicos acepte su seguro medico, y también acepte el programa de Niños con Necesidades Especiales de Atención Medica. (Enviaremos este formulario a su compañía de seguro para que la completen).

Llene solo las siguientes secciones:
En el lado izquierdo escriba el nombre y dirección de su compañía de seguro.
En el lado derecho escriba la información requerida.
NO CONTESTE LAS PREGUNTAS DEL 1 al 6 – estas preguntas son para su proveedor de seguro.

En la parte baja de la página firme, ponga la fecha y la relación del asegurado. REGRESE ESTE FORMULARIO CON SU APLICACIÓN.

INFORMACIÓN DE PADRES DIVORCIADOS/SEPARADOS

Padres separados (sin documentación) cuentan como familias intactas – necesitan someter con la aplicación la dirección y verificación de ingresos del padre ausente. El padre ausente es igualmente responsable del niño(a).

Separación legal – Requerimos una copia de los documentos legales de la corte. Someta la dirección del padre ausente si el documento de la corte indica que el padre ausente también es responsable de las cuentas medicas del niño(a).

Padres divorciados – Servicios de salud para la Familia cumple con el decreto de divorcio aprobado por la corte y documentos de la custodia del niño(a). (Necesitamos la dirección del padre ausente – si ese padre tiene custodia por igual o si es igualmente responsable en parte de las cuentas medicas). Le enviaremos as ese padre una aplicación para que llene su porción. A el/ella le será asignado el 100% de su mitad de las cuentas medicas por fallar en regresar su porción de la aplicación.

GUARDIÁN/ABUELOS – Servicios de Salud para la Familia solamente acepta aplicaciones con documentación legal de la corte señalando tutela del niño. Declaraciones notariadas **NO** son aceptables. Usted necesitara también aplicar para el programa de Welfare – non needy caretaker. Necesitaremos una copia de la determinación del Welfare para poder continuar con el proceso de la aplicación.

DOCUMENTOS REQUERIDOS CON LA APLICACIÓN – NECESITA ENVIAR COPIAS DE ESTOS DOCUMENTOS CON SU APLICACIÓN. NO ENVIE DOCUMENTOS ORIGINALES

Copia de acta de nacimiento.
Copias de estado de ciudadanía o inmigración/copia de tarjeta de residencia.
Copia de la tarjeta de seguro social para la persona quien esta aplicando.
Copias de 3 diferentes talones de cheques del empleador presente de todas las personas que trabajan en su hogar. Indique como es que le pagan: semanal, cada dos semanas, o mensual etc.
Copias del formulario W-2
Si tiene su propio negocio-adjunte copias de reembolso de impuestos del año anterior.
Copias de premios o copias de cheques de todos los ingresos señalados arriba.
Copias de informes mas recientes de acciones, bonos, ahorros, fondos fiduciarios, 401K, IRA'S
Información respecto a cualquier litigación/daños relacionados con lesiones al cliente que esta inscribiéndose en el programa.
Copias de todos los documentos de divorcio/separación y ordenes de la corte para el sostén del niño (a).
Copias de documentación indicando la paternidad de la persona por la cual usted esta aplicando
Copia de la tarjeta de seguro medico (de frentes y detrás).
Copias de cualquier documentación sobre la realización de adopción del niño (a).
Copia de la carta Determinación de Beneficios (ejemplo negación de Seguro Medico, Medicaid o Nevada Check Up etc).
Formulario de Verificación de Seguro Medico.
Firme el Formulario Medico para Liberar Expedientes Medicales.

REGRESE TODOS LOS FORMULARIOS A:

NEVADA STATE HEALTH DIVISION
Bureau of Family Health Services - CSHCN
3427 Goni Road, Suite 108
Carson City, NV 89706-4245
Phone: (775) 684-4285 Fax: (775) 684-5840
Toll free: (866) 254-3964

CASE NUMBER

EFFECTIVE DATE

CLOSED DATE:

CSHCN | Registry

NEVADA STATE HEALTH DIVISION
BUREAU OF FAMILY HEALTH SERVICES-cshcn
3427 GONI ROAD, SUITE 108
CARSON CITY, NEVADA 89706
PHONE: 775)684-4285 FAX: (775)684-5840

FAMILY NOTIFIED _____
ID CARD SENT _____
PRIVACY POLICY _____
LEGAL STATUS:_____

NEW ☐
UPDATE ☐
REOPEN ☐

OTHER CHILDREN IN CSHCN
_____
_____
_____

REFERRED TO: ✔ **UP:** ☐ **MEDICAID:** ☐ **SSI:** ☐ **CHILD SUPP:** ☐ **BEIS** ☐ **OTHER** ☐
DATE REFERRED: _____ _____ _____ _____ _____ _____
DATE APPROVED: _____ _____ _____ _____ _____ _____

DO NOT WRITE IN SHADED AREAS

CLIENT'S NAME (LAST, FIRST, M.I.) M ☐ F ☐ BIRTHDATE AGE SS NO:

CLIENT'S ADDRESS: COUNTY:

CLIENT LIVES WITH: BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ SELF ☐ SPOUSE/PARTNER ☐

ETHNIC BACKGROUND
CAUC. ☐ BLACK ☐
AMER. IND. ☐ SPAN. ORIG. ☐
ASIAN/PI. ☐ OTHER ☐

HOME PHONE:_____
WORK, FATHER/SPOUSE:_____
WORK, MOTHER/CLIENT:_____
MESSAGE PHONE:_____

Marital Status/Parents/Client:

MOTHER: MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOW(ED) ☐

FATHER: MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOW(ED) ☐

CLIENT: MARRIED ☐ SINGLE ☐ DIVORCED: ☐ SEPARATED ☐ WIDOW(ED) ☐

CUSTODY STATUS: **PHYSICAL CUSTODIAN:** MOTHER ☐ FATHER ☐ JOINT ☐ **LEGAL CUSTODIAN:** MOTHER ☐ FATHER ☐ JOINT ☐

HEALTH INSURANCE: **DEPENDENT COVERAGE:** YES ☐ NO ☐

POLICY HOLDER: INSURANCE COMPANY NAME COMPANY ADDRESS POLICY GROUP ID NO. EFFECTIVE DATE

MEDICAL INFORMATION	LAST SEEN	ADDRESS	PROVIDER #	REC.REQ.	MED.HOME
				YES NO	YES NO
FAMILY PHYSICIAN/CLINIC					
SPECIALIST *(CLIENT REFERRED TO)*					
SPECIALIST *(CLIENT REFERRED TO)*					
HOSPITAL *(CLIENT PREVIOUSLY ADMITTED TO)*					

Condition for which referral is made: 1) describe nature of physical handicaps: 2) give pertinent medical history including resume of care and dates; 3) give the services providers are requesting at this time. _____

_____

_____

PHYSICIANS DIAGNOSIS	PRES.	EST.	ICDA CODE
1.			
2.			
3.			
4.			

DATE RECEIVED

INCOME:

HOUSEHOLD COMPOSITION: INCLUDE ALL INCOME INTO THE HOUSEHOLD.

RELATIONSHIP	LIST FULL NAME	DOB	SOC. SEC. #	*GROSS ANNUAL INCOME	HOW OFTEN PAID
1. CLIENT				$	
2. MOTHER				$	
3. FATHER/HUSBAND				$	
4.					
5.					
6.					
7.					
8.					

*FILL IN ORDER BELOW

EMPLOYER AND ADDRESS: **OCCUPATION:**

1. _____

2. _____

3. _____

OTHER INCOME RESOURCES WITHIN FAMILY:
(I.E., SSI, CHILD SUPPORT, DISABILITY, TIPS, ETC.)

_____

_____

GROSS LIQUID ASSETS:
(SAVINGS, STOCKS, BONDS, IRA'S, 401K'S, ETC.)

_____

_____

NUMBER DEPENDENT ON INCOME _____

TOTAL RESOURCES: $

SUPPORTING DOCUMENTS ATTACHED

ABSENT PARENT'S NAME: FATHER/MOTHER OF CLIENT _____
COMPLETE ADDRESS _____
FATHER OF UNBORN: _____
COMPLETE ADDRESS _____

OTHER PERTINENT INFORMATION *(USE ADDITIONAL SHEET IF NECESSARY):*

_____

_____

_____

CERTIFICATION AGREEMENT

I CERTIFY I HAVE READ THIS APPLICATION FOR FAMILY HEALTH SERVICES ASSISTANCE (OR HAD IT READ TO ME) AND I UNDERSTAND THE INFORMATION REQUIRED. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

_____ _____

SIGNATURE OF APPLICANT/CLIENT DATE

****YEARLY UPDATE IS REQUIRED TO CONTINUE ELIGIBILITY**

NOTICE TO APPLICANTS: YOU HAVE THE RIGHT OF APPEAL SHOULD THERE BE A SUBSTANTIAL DISAGREEMENT WITH ANY DETERMINATION MADE AS THE RESULT OF THE APPLICATION REGARDING FHS FINANCIAL SUPPORT OR YOUR SHARE OF THE COST OF SERVICES.

_____

BUREAU REPRESENTATIVE AND FACILITY

NEVADA STATE DIVISION OF HEALTH
FAMILY HEALTH SERVICES
3427 Goni Suite 108
Carson City, Nevada 89706

APPLICANT / CLIENT RESPONSIBILITY AGREEMENT

Between applicant / client and the Nevada State Division of Health, FAMILY HEALTH SERVICES, hereafter referred to as FHS:

1. I understand that after I have been told about the decision made by the Health Division regarding my application, if I am not satisfied, I have the right to a fair hearing. If I feel I have been discriminated against because of race, color, sex, religion or national origin, I have the right to file a complaint with the Nevada State Health Division, 505 E. King Street, Room 200, Kinkead Building, Carson City, Nevada 89701-4792.

2. I understand that if I do not assist the Health Division and appropriate authorities the establish paternity and/or to try to seek father's participation in medical costs for his child, I will not be eligible for FHS financial support for medical services.

3. I hereby authorize the Nevada State Health Division to make any investigation concerning me, my dependant and my children's legal parent(s) which is necessary to establish my initial or continued eligibility for assistance. This authorization constitutes a full and complete release from any liability resulting from disclosure of required information to the appropriate authority.

4. I agree to notify the Nevada State Health Division **immediately** when there is any change in my situation that might affect my eligibility for assistance. This would include change in address, name, assets, property, and income or change in income of myself or any member of the household, number of children attending school, number of persons living in the household, change in living arrangements, health insurance, or any other fact that could affect my eligibility for assistance.

5. I understand that approval of the application must be made before care can be provided through FHS. The approval of the application and any financial assistance is dependent upon confirmation that I or my child has an **eligible FHS medical condition** and upon the authorization by myself to permit FHS to investigate my financial status and to determine my **financial responsibility** regarding full/partial/or no payment of any medical costs authorized by FHS in relation to services requested under this application.

6. I understand the determination of an eligible medical condition under FHS may be delayed until the hospitalization is complete and medical records are reviewed by FHS.

7. I realize that I must give complete and accurate information, that I must cooperate with the Division to establish initial and on-going eligibility; and that willful concealment of income and assets could result in criminal prosecution.

8. I agree that if money is awarded from a public fund drive, litigation or settlement, I will advise FHS. Also, I understand that this money is to be used prior to FHS funds toward payment for provider medical services and/or related costs. For services already paid, FHS may require reimbursement. I will keep FHS informed of all steps taken to recover damages, this includes the name of my attorney and dates of any court hearings.

9. I understand and agree that for conditions not covered by FHS **I am liable** to the provider for the entire cost of services.

10. I agree to abide by any repayment determination.

11. I agree to show my FHS Identification Card to each and every provider of services to the child or myself for whom I am responsible.

12. I agree to notify each and every provider of services of any insurance coverage including CHAMPUS and supply them with the necessary forms. I agree to assign any insurance payments that I receive or am eligible to receive to those providers of care.

13. I understand that failure to apply for recommended prior resources, complying with all required guidelines, will automatically void my FHS application. Also, if accepted into a prior resource program, I agree to advise FHS and all providers of care of this fact.

14. I agree that if EMERGENCY SERVICES are given:
    a. During normal working hours (8-5, M-F) that FHS is notified by telephone the same day.
    b. Outside of normal working hours, that FHS is notified by telephone the next working day.

15. I agree to update the application before the expiration date and recognize that failure to do so will result in my termination for FHS eligibility.

16. I agree to notify FHS of the date of scheduled APPOINTMENTS and/or hospitalizations with any physician prior to the date of visit so that this service can be reviewed for possible authorization prior to the date of service.

I have read, or have had read to me, and understand the above agreement. I understand that failure to comply with the agreement stipulations can result in termination of my eligibility from this FHS program. I acknowledge receipt of a copy of this agreement.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Persons Helping to Complete Form Date

(Use if applicant cannot read, or write, or is blind)

I have heard the information contained in this application read to the applicant and have witnessed the signature above and witnessed that the applicant received the copy.

WITNESS:

_____ _____
Signature Date

_____
Address

IF YOU HAVE QUESTIONS REGARDING THE PAMPHLETS AND FORMS GIVEN TO YOU, PLEASE ASK YOUR PROGRAM REPRESENTATIVE.

WHITE – FHS, CANARY – Applicant/Client

STATE OF NEVADA
DIVISION OF HEALTH
BUREAU OF FAMILY HEALTH SERVICES-CSHCN
3427 GONI ROAD, SUITE 108
CARSON CITY, NEVADA 89706-7972

PHONE: (775) 684-4285 FAX: (775) 684-5840
1 (866) 254-3964

CHILDREN'S SPECIAL HEALTH CARE NEEDS PROGRAM

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize
[Name of Parent or Legal Guardian, or Patient [if Patient is an adult]

_____
[Name of Physician, Laboratory, or other health care provider]

To Submit/ Disclose Medical Records (Protected health Information) of:

_____
[Patient name and date of birth]

To: Bureau of Family Health Services-CSHCN Program so that the program may:

1) Establish eligibility for program assistance OR
2) Pay bills for authorized services according to regulations currently in force (NRS 442-700)

This authorization shall be in force and effect until _____
[Date or event upon which authorization expires]

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that protected health information has been used to release in reliance upon this authorization at the time of revocation. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by the federal or state law. I understand that my treatment may not be conditioned upon whether I provide authorization for the requested use or disclosure except as required by law.

Signature_____ Date _____
[Signature of Parent or Legal Guardian, or Patient [if Patient is an adult]

Complete the following if authorization is given on behalf of the patient by parent representative:

_____ _____
[Name of Personal Representative] *[Relationship to Patient]*

NEVADA STATE DIVISION OF HEALTH
BUREAU OF FAMILY HEALTH SERVICES - CSHCN
3427 Gonit Road, Suite 108
Carson City, Nevada 89706-7972
Phone: (775) 684-4285 Fax: (775) 684-5840

INSURANCE VERIFICATION

To be Completed by Applicant:

Insurance Company Name & Address: _____

_____

_____

_____

Insured: _____

Thru: _____

Policy # _____

Patient: _____

Date: _____

To be Completed by Insurance Representative:

Gentlemen:

Please be advised that the above named client has applied for assistance with the Family Health Services CSHCN program. Since insurance is classified as a prior resource to governmental programs, this office would appreciate the following information:

1. Date insurance became effective. _____
2. Date insurance terminated. _____
3. Does insured have dependent coverage? _____
4. Will your insurance company cover medical care that is necessary and appropriate for this patient, including pregnancy? _____
5. a. Any pre-existing conditions? _____
   b. Length of pre-existing limit? _____
6. Specific policy limitations, medical and/or payment, i.e. preferred providers: _____
   _____
   _____

Family Health Services

I agree to the above request and authorize the insurance company to release the information requested to the State of Nevada Bureau of Family Health Services CSCHN Program so that they may process this case for approved services.

_____

Insured(s) representative **Relationship** **Date**

Nevada State Health Division * Bureau Of Family Health Services Children With Special Health Care Needs Program.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's notice of Privacy Practices:

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

A written acknowledgement of Receipt of our Notice of Privacy Practices was attempted; however, acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other

NOTICE OF PRIVACY PRACTICES

Bureau of Family Health Services –Children with Special Health Care Needs

This notice describes how medical information about you or your child may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Bureau of Family Health Services Privacy officer at the following number: (775) 684-4285

This Notice describes your right to access and control your or your child's medical records, known as protected health information or PHI. This Notice also describes our privacy practices and legal duties concerning how we may use and disclose protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by both state and federal law. Our office and staff will follow the privacy practices that are described in this Notice while it is in effect. When new regulations are created, we will update this Notice. This Notice takes effect June 04, 2004, and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information

Your or your child's protected health information may be used for treatment, payment, and healthcare operations. The following are examples of the uses and disclosures:

Treatment: We will disclose your or your child's protected health information to a physician or other healthcare entity providing treatment to you. For example, we may provide your or your child's protected health information to a physician, with whom you or your child has been referred, to diagnose or treat you or your child.

Payment: We may use and disclose your or your child's protected health information, as needed, to obtain payment for your or your child's health care services. For example, we may include certain activities that your or your child's health insurance plan may undertake before it approves or pays for the health care services rendered.

Healthcare Operations: We may use or disclose, as needed, your or your child's protected health information in connection with our healthcare operations. This may include quality assessment activities, employee review activities and training, certification, accreditation, and licensing.

You may give us **Authorization** to use or disclose your or your child's health information to anyone you specify for any purpose. If you do not give us **Authorization,** we cannot use or disclose your child's protected health information for any reason except for treatment, payment, and healthcare operations, or as required by law. At anytime you may revoke your **Authorization** in writing, except to the extent that we have already taken action in reliance upon the **Authorization.**

Family and Friends: If you agree, we may disclose your or your child's protected health information to a family member, friend or other person to the extent the Privacy Rule allows as defined in this Notice.

Other Persons Involved In Care: Unless you object, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your or your child's care, of your or your child's location, general condition or other personal information. Additionally, using our professional judgment, we may allow a person to pick up your or your child's medical supplies, x-rays, or other similar forms of health information. In case of an emergency, we may use or disclose your or your child's protected health information that is directly relevant to the person's involvement in your or your child's healthcare.

Marketing: Our office will not use your or your child's protected health information for marketing purposes without your prior written authorization except for a face-to-face encounter or a communication involving a promotional gift of nominal value.

The Law: Our office will use or disclose your or your child's protected health information if and when either state or federal law requires it. If requested, you will be notified of any such uses or disclosures.

Other Uses or Disclosures of Your Child's Protected Health Information: If we reasonably believe that your child is a victim of abuse, neglect, domestic violence, or other crimes, we may disclose your child's protected health information to the proper authorities. We may disclose your or your child's protected health information for **public health activities** and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your or your child's protected health information to authorized federal officials for conducting **national security**, and **intelligence activities.** We may also disclose protected health information if it is necessary for **law enforcement authorities** to identify or apprehend an individual, or in response to a subpoena, discovery request or other lawful process. We may also disclose your or your child's protected health information to **researchers** when an institutional review board has approved their research. We may also use or disclose your or your child's health information to provide you with **appointment reminders**.

You and Your Child's Individual Rights

Access: By written request, you have the right to **inspect** or **receive a copy** of your or your child's protected health information in part or in full. You may request an alternative format for copies of your or your child's information. We may charge you a reasonable cost-based fee for providing copies of your or your child's health information. Please feel free to contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Amendment: You have the right to request an amendment of your or your child's protected health information. This request must be in writing and must explain the reason for such an amendment. We may deny your request under certain circumstances.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your or your child's protected health information, other than for treatment, payment, and healthcare operations. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003 for up to 6 years.

Restrictions: You have the right to request restrictions on certain uses or disclosures of your or your child's protected health information; however, we are not required to agree to a restriction that you may request. If we do agree to your request, we will abide by our agreement except in an emergency.

Alternative Communication/Location: By written request, you have the right to receive confidential communications from us by alternative means or at an alternative location. We will not request an explanation from you as to the basis for the request; however, we may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

Electronic Notice: If you agree to receive this Notice electronically, you may also request a paper copy.

Our Duties: The Children with Special Health Care Needs program is required by law to maintain the privacy of your or your child's protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice currently in effect, and we reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain about you or your child. If a new Notice is created that contains material changes in our privacy practices, the new Notice will be mailed to you.

Complaints: If you believe that your or your child's privacy rights have been violated, you may file a written complaint with either our office by using the contact information listed below, or with the U.S. Department of Health and Human Services.

The Secretary of Health and Human Services

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.

Washington, D.C. 20201

If you do choose to file a complaint, we will not retaliate in any way.

We support your right to the privacy of your or your child's health information. If you would like more information about our privacy practices, or have questions or concerns, please feel free to contact us.

Contact: Bureau of Family Health Services Privacy Officer

Telephone: (775) 684-4285 Fax: (775) 684-4245

Address: 3427 Goni Road, Suite 108,

Carson City, NV 89706